CHRISTOPHER BIR, M.D.

Child, Adolescent, and Adult Psychiatrist

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AUTHORIZATION FOR RELEASE OF INFORMATION FOR CHILDREN / ADOLESCENTS

I, _____, the parent / legal guardian or _____ , born on _____, hereby consent to and authorize Dr. Christopher Bir to ☐ release to ☐ receive from:

_____

_____

_____

_____

any and all information and records including diagnosis, treatment, history, laboratory data, imaging data, and psychological testing. In addition, I hereby authorize Dr. Christopher Bir to discuss any and all aspects of my child's treatment with the above identified person/party and to provide them with records of my child's treatment as treatment may indicate.

I also understand that my child's insurer may require information regarding my treatment.
I agree to have this information released as requested.

This authorization will terminate in one year from the signed date or when I have requested to do so in writing.

_____ _____

SIGNATURE OF LEGAL GUARDIAN DATE

_____ _____

WITNESS DATE